Debunking "Meth Myths"

By Nicolas Taylor, Ph.D.

"Nothing is as simple as we hope it will be"

— Jim Horning

To say that addiction to methamphetamine is a complicated problem is an understatement. Across the country, and now even throughout the world, treatment providers and human service professionals alike are discovering the complex web of behavioral disruption, criminal lifestyles, collusive and insidious relationships, neurological damage and psychological mayhem that characterize the overall picture of a meth-using community (Anglin *et al.*, 2000).

However, complex problems don't always require complex solutions, but they do require solutions of some kind. Community awareness, with perhaps the exception of first responders in law enforcement, lags months, even years, behind actual community problems. Because of the nocturnal and underground nature of the "meth community," general awareness of the chaos of the "crystal kingdom" can often go unrealized until it has spread like a cancer throughout a community and has started to dangerously affect innocent victims like children of meth users, victims of property crimes, theft, check fraud, identity fraud and damaged rental properties, to say nothing about public exposure to environmental toxins because of local meth production.

Perhaps the most vulnerable population in the community are its adolescent young women who, either because of abuse or neglect by their parents or fate, are enticed deep into the dark under belly of the meth-using community by

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Honorable Pat Escher is the presiding judge of the juvenile court. A morning staffing and subsequent court hearing is followed by an afternoon staffing and hearing. So that no participant is required to attend the entire day, attendance schedule options are available. Camaraderie among team members observed in the staffing is also clearly present at the court appearance. Rather than celebrate days of sobriety, Judge Wagener finds a participant to either be in or out of compliance. The emphasis is on the parent's success in all aspects of her/his functioning, not only on remaining sober.

Judge Wagener greets the families with affection and is clearly knowledgeable about their lives and rewards them with positive feedback. In speaking to a young mother about her new-found sobriety and increased visitation rights, the judge said, "What a gift you gave to your boys; what a gift you gave to yourself."

Sanctions are also given as needed on a timely basis. In addition to assigning essays, Judge Wagener gives participants who need to ponder their actions upon relapsing, a "functional analysis" exercise so that they can begin to identify non-productive behaviors. Incarceration is used sparingly, but when a participant is discharged from a 48-hour stay, team staff is there to take them to their next treatment or 12-step program, thus ensuring the likelihood of success.

FDTC Coordinator, Chris Swenson-Smith, SAMHSA Project Director, reports that child protective reports have increased dramatically in the last several years in Pima County. However, with this Team's collaboration and commitment, the needs of the community are being served and a different future will be created for young families and their children.

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promises of romance from older men, slender figures, unrestrained energy and an endless high that pot using or drinking teenagers will never achieve or appreciate.

"Meth was great! I loved it from the first time (41 year-old boyfriend) got me high. It was cheaper than pot and easier to get than alcohol. Plus it kept me thin, and I know that made him happy."

— 16 year-old female meth user

The complexity of meth addiction and "the speed of speed," (meaning how quickly use of this drug acts to completely disrupt the life of a user and how quickly it spreads through an unsuspecting community) make community responses reactive for those who do attempt to address the problem. First solutions always involve a law enforcement response, mainly because, as was mentioned, they are the first to find out about it. Dutiful peacekeepers do what they know how to do best. That is, find those who perpetrate crimes and arrest them so a just legal system can balance their "debt to society" with a rehabilitative effort to make it so the person does not return to the criminal behavior. Very quickly, however, the inadequacy of these solutions becomes apparent as law enforcement officers and judicial leaders alike become frustrated because they see the same people again and again. It is as if they don't learn their lesson, or as if the kinds of tools that work to teach other people their lesson don't seem to work with this population.

"It drives me nuts. We arrest a meth'er, send him to jail and then think, yeah there we go, I just did my job, but then it seems like before you can blink he's out, doin' the same things he's always done and burning the same people he's always burnt. The cycle is sick."

— Police Officer with 15 years experience

Inevitably, then, public attention turns to treatment professionals and the thinking reaches a brief moment of compassion in which it is figured, "If this person can just get the help they need, then they will stop doing this." The question hardly asked by those attempting to corral the scared, although unenthusiastic, and often unwitting, addicted offender into treatment is, "So, exactly what is the help this person needs?" That is seen as someone else's concern and since effective treatment programs seem to mask their skills and interventions behind a veil of patient confidentiality, it is as if the public can't know exactly what treatment entails even if they did want to make it their concern. But, the problems are too involved, and, as was mentioned, too complicated for one treatment professional or one treatment agency to really do much about it. The tide of the using community and the pull of the psychological and physical addiction to the drug are so powerful that they overwhelm even the well-intended or well-trained treatment professional. Short-term gains, made perhaps when the user was still in a state of shell shock from having been caught, fade quickly. Long-term change begins to seem much more unrealistic and the addicted patient's case seems much more hopeless and the prognosis much poorer.

So, myths are perpetuated. "Once somebody tries meth they can't ever stop. They end up either killing themselves, killing somebody else or brain dead." And, "treatment doesn't work, because once people are out of treatment they just go right back to using." Myths, however, by definition are untrue. Of course it can't be true that everyone who tries meth is addicted for life until death, and it can't be true that no treatments work or that treatment efforts are only a waste of time since meth is the one drug from which no one can ever truly recover. In spite of this, the pessimism of those working with meth addicts continues to grow and the mounting need for theoretically sound and effective treatment emerges as the headline issue upon which all other community efforts rest.

The primary barrier to treatment, however, is not necessarily the addicted user and all of the challenges posed purely by their addiction but instead it is battling the long perpetuated myths about treating addiction to methamphetamine. The purpose of this

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article is to attempt to debunk many of the myths about the treatment of methamphetamine addiction. As these exaggerated and poorly supported beliefs are effectively addressed communities will be more able to focus on actual problems at hand as opposed to the Chicken Little-like paranoia created by meth myths.

Myth #1: Only 6 percent of meth addicts get and stay sober.

This statistic was given at the conclusion of the 2003 HBO documentary "Crank: Made in America," but no reference was provided for its source. The fact of the matter is that people can and do recover from methamphetamine addiction. Outcome data reported by the National Association of State Alcohol and Drug Abuse Directors (NASADAD, 2005) show that:

- In the State of Colorado during 2003, 80 percent of meth users were abstinent at discharge from treatment.
- In the State of Iowa, a 2003 study found that 71.2 percent of meth users were abstinent six months after treatment.
- A 2002-2003 study done by the Tennessee Bureau of Alcohol and Drug Abuse found that 65 percent of meth clients were abstinent six months after discharge from treatment.
- The Texas Department of State Health Services examined outcome data for publicly-funded services from 2001-2004 and found that approximately 88 percent of meth clients were abstinent 60 days after discharge.
- Utah's Division of Substance Abuse and Mental Health reported that in State Fiscal Year 2004, 60.8 percent of meth clients were abstinent at discharge.

In addition, a recent study of 978 methamphetamine dependent individuals receiving treatment at eight outpatient treatment programs in the states of California, Montana and Hawaii, found that:

- Of those enrolled in the programs, 40 percent successfully completed them (maximum length, 16 weeks).
- Of those who completed treatment, 69 percent tested negative for methamphetamine use during their discharge interview and then again six months later (Rawson *et al.*, 2004).

The magical rule of thirds seems to apply to methamphetamine treatment as it does to treatment for addiction to other substances and for other chronic illnesses (*i.e.* diabetes, obesity, high blood pressure) as well.

- About one third of people who start treatment successfully complete it and then remain abstinent.
- About one third drop out during treatment and do not return.
- A final third do not successfully complete treatment THIS TIME, but are able to do so later.

Myth #2: People who want to be in treatment always do better than those who are forced to be there.

In a recent study, Brecht, Anglin and Dylan (2005) found that meth treatment outcomes (defined as treatment completion, relapse within six months, time to relapse, and percentage of days with Meth use in 24 months following treatment) did not differ significantly in simple comparisons between the coerced and non-coerced groups.

Following a review of research regarding various efforts designed to facilitate entrance into treatment and retention in treatment Marlatt *et al.* (1997) concluded that:

"Although court-ordered treatment has become increasingly common, traditional views of the essential role of client motivation in help-seeking and behavior change imply that coerced clients are more likely to have poor outcomes compared to volunteers. However, studies that compared treatment participation and outcomes among coerced and voluntary clients found similar outcomes across groups and reduced attrition among coerced clients."

The difference appears to simply be related to retention. Almost regardless of treatment program, the best predictor of treatment success is how long the person stays engaged in the treatment process (Rawson *et al.*, 2004). Involuntary, court ordered clients have the added therapeutic benefit of extrinsic factors assisting with retention.

Myth #3: All Meth addicts need inpatient treatment.

It is commonly believed that until a person addicted to meth is separated from community forces (situations, places, cues and people) associated with their use, they will never be able to stop doing it. For this reason inpatient treatment is perceived as the only treatment option for people addicted to meth. Well, since in the end relapse prevention all comes down to what the individual is able to do in their natural environment inpatient treatment is only as good as the outpatient follow-up. Moving straight to inpatient treatment for a client for any other reason than the issue of personal and/or public safety never allows the chance for the person to see of they can make it in outpatient treatment. Even if they can't and relapse the first day of outpatient treatment, they have been firmly indoctrinated in the concept that treatment is all about helping them to be able to deal with their home environment in a way that helps them to stay sober and not about helping them to escape it. In perfect models, inpatient treatment is used almost as a case management ATU (acute treatment unit) which has as its sole design client stabilization and return to outpatient treatment since it is in the outpatient setting that people most need to be able to practice their sobriety skills.

Myth #4: It takes at least one year for treatment to work.

This is a tricky myth because it is true that meth addicted individuals are unlikely to experience much benefit from short (less than three months) treatment experiences. However, it is not the one year in treatment that determines whether or not it has worked, it is behavior change that determines whether or not treatment has worked.

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Like the individual process of recovery, the family process is usually not linear; there are times of great triumph and times of terrible anxiety. FTC's have the capacity to nurture family recovery when they understand the process and use their power to embrace the entire family of the respondent.

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Too much focus on the duration of treatment can actually be harmful because the addicted client may begin to believe that the goal of treatment is for them to stay a certain amount of time and not necessarily for them to make identified key changes in their life. Meth treatment is not like putting something in an oven and waiting for a kitchen timer to go off advising that the addicted individual is "done." Key areas of change must be identified and solidified as the essential purposes of treatment. Everything else is incidental to accomplishing the identified changes. These changes must be objective, and easily measured. They can include things like:

- Periods of verified abstinence.
- Periods of verified distancing from identified individuals.
- Verified stable sleeping patterns and eating patterns.
- Other verified stable living patterns such as employment and child care.

Other myths that still perpetuate in the treatment field include the myth that treatment providers can effectively address an individual's meth addiction with little or nor community support from other individuals or agencies; and that making meth addicted individuals feel bad and shameful about their behavior will motivate them to want to change it.

Treatment for meth addiction is complex and complicated. But so is treatment for all substances of abuse. Debunking some of the myths about meth treatment will help avoid unnecessary overreactions to the challenges of community based efforts to treat meth addiction.

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